

Return Application With
Check Payable To:
Treasurer – State of NH
Annual Fee: \$250

State of New Hampshire
Board of Pharmacy
121 South Fruit Street
Concord, NH 03301-2412
Tel: (603) 271-2350 Fax: (603) 271-2856
Website: www.nh.gov/pharmacy/

Board Use Only (Do Not Write In This Box)

**MANUFACTURER, WHOLESALER / DISTRIBUTOR,
OR BROKER OF PRESCRIPTION DRUGS AND/OR DEVICES**
FOR SALE OF PRODUCTS AT WHOLESALE ONLY

APPLICATION FOR PERMIT TO CONDUCT BUSINESS IN THE STATE OF NEW HAMPSHIRE

July 1, 2014 – June 30, 2015 Licensing Period

☐ Check here if this application is being submitted as part of a ***change of ownership*** for a current NH licensed manufacturer/wholesaler/distributor. If so, enter current NH License # _____

Location Of Facility Where Actual Manufacturing / Distribution Takes Place (If Broker Only, Business Mailing Address):

Company Name

Street Address

City

State

Zip Code

Parent Company (If None, Write "None"):

State Of Incorporation (If Corp.):

Nature Of Business (Check **ALL** That Apply):

☐ **Manufacturer*** ***If checked, is your company currently registered/licensed by the FDA?***

☐ Yes ☐ No

☐ Wholesaler/Distributor ☐ Broker ☐ Other (Attach Explanation)

Doing Business As:

☐ Sole Proprietorship ☐ Partnership

☐ Corporation ☐ LLC

Telephone:

E-Mail Address (Contact Person for Board Inquiries Regarding Application):

DEA Number (If Shipping Controlled Drugs): ***Attach Copy Of Permit With Application**

State Controlled Substance Lic. #, If Applicable: ***Attach Copy Of Permit With Application**

Federal Tax ID # (FEIN):

Name Of Owner(s): Indicate Individual, Partners, Etc. (If Corporation, Show Title Of Officers). Attach Additional Sheet If Necessary.

Name Address Title

Name Address Title

Name Address Title

Provide the name, address, & title of the person to whom the permit and/or renewal application should be directed:

Name: Title: Tel. #:

Business Mailing Address:

DO NOT LEAVE ANY BLANK SPACES – IF NOT APPLICABLE, WRITE 'N/A' & THE REASON IT DOES NOT APPLY

APPLICATION CONTINUED ON NEXT PAGE ➔

Is the above referenced company (physical location) licensed by the board of pharmacy or other licensing agency in the state of location?
☐ Yes * ☐ No * *(If "yes", attach a copy of the state license/permit & the most recent inspection. If No, attach letter explaining why licensure is not required in home state – a letter from home-state's licensing agency / Board of Pharmacy is preferred).

In the past 3-years has the registration or licensure granted to the above referenced company been suspended, revoked, or otherwise disciplined by any state or federal agency? ☐ Yes * ☐ No * (If "Yes", attach a detailed explanation)

If shipping controlled drugs, provide the name, address, telephone & fax # of the person to whom communication regarding controlled substance distribution records may be directed:

Name: _____ Telephone #: _____ Fax #: _____
Business Mailing Address: _____

Which of the following entities do you sell / ship to?

- ☐ Retail Pharmacies ☐ Hospital Pharmacies ☐ Physicians ☐ Dentists
☐ Veterinarians ☐ Other Wholesalers ☐ Other _____

Categories of product being sold / shipped into New Hampshire at wholesale?

- ☐ Controlled Substances ☐ Human Prescription Drugs ☐ Veterinary Prescription Drugs
☐ Prescription Devices(At Wholesale) ☐ Medical Gases (At Wholesale) ☐ Other _____

Declaration And Signature Of Company Representative:

I have attached the following required documents:

(ALL REQUIRED ATTACHMENTS MUST BE SUBMITTED OR YOUR APPLICATION WILL NOT BE PROCESSED)

I confirm that the following attachments have been attached to this renewal form:

- ☐ 1. A copy of the facility's current license/registration issued by the Board of Pharmacy or other state regulatory agency where the facility is located (home state);
- ☐ 2. A copy of the facility's current Federal DEA Registration Certificate if shipping controlled drugs;
- ☐ 3. A copy of the facility's most recent inspection report issued by either the FDA, NABP / VAWD Accreditation, or State Board of Pharmacy where the pharmacy is located (home state).
- ☐ 4. Check for \$250 payable to "Treasurer – State of NH".

I affirm that I am the person authorized to sign this application for licensure and declare under penalties of perjury that this application (including any accompanying documents) has been examined by me and to the best of my knowledge and belief is a true, correct and complete application, and if the registration herein applied for is granted, I hereby agree to and do submit to the jurisdiction of the New Hampshire Board of Pharmacy and to the laws and rules of this State. My signature below also affirms that I have reviewed the laws/rules regarding prescription drug/device manufacturers/wholesalers/distributors found at http://www.nh.gov/pharmacy/laws/mft_whole.htm and agree to abide by those regulations.

Signature: _____ Title: _____ Date: _____

INCOMPLETE APPLICATIONS OR APPLICATIONS WITHOUT REQUIRED ATTACHMENTS WILL NOT BE ACCEPTED.

DO NOT LEAVE ANY BLANK SPACES – IF NOT APPLICABLE, WRITE N/A & THE REASON IT DOES NOT APPLY SO WE KNOW YOU DID NOT MISS A QUESTION.

ANY SUBSEQUENT CHANGES TO THE INFORMATION ON THIS FORM MUST BE REPORTED TO THE BOARD IN WRITING WITHIN 30 DAYS.